

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH



C6680

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1152 Oakes St., N.E.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ADAMS, Alvie Clark

## 3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>W-US</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
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6.(b) Name of husband or wife Mrs. A. C. Adams7. Birth date of deceased (mo., day, yr.) 21 January 1892

8. AGE:	Years <u>54</u>	Months <u>4</u>	Days <u>8</u>	If less than one day .....hrs. ....min.
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9. Birthplace Va.  
(Town, county, and state)10. Usual occupation Veteran

11. Industry or business

12. Name John F. Adams13. Birthplace Va.14. Maiden name Margaret Neff15. Birthplace Wash., D.C.16. Informant wife: Mrs. A. C. AdamsAddress 1152 Oakes St., N.E. Wash., D.C.17. burial Date thereof 6-12-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director Deal Funeral HomeAddress 816 H St., N.E. Wash., D.C.19. 6-9- 46 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9 June 19 46 at 7:40 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 June 19 46, fo. 9 June 19 46and that I last saw h. in alive on 9 June 19 46Immediate cause of death Carcinoma of the esophagus

Due to

Due to

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

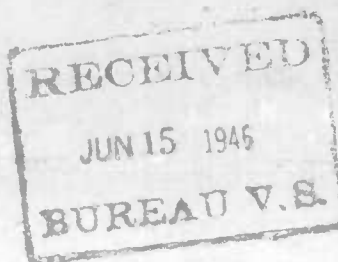
Other conditions

Other conditions

Other conditions

Other conditions

Other conditions



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

## CERTIFICATE OF DEATH

★ 06081216  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chesapeake  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chesapeake, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 327 Willard Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American

## 3. (a) FULL NAME

HARRY DESALES ADAMS

## 3. (b) Social Security Number

577-09-1946

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1881 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years Months Days If less than one day  
64 8 23 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation Salesman11. Industry or business Retail liquor store12. Name Harry D. Adams13. Birthplace Boston, Mass14. Maiden name Annie J. Lowe15. Birthplace Baltimore, Md.16. Informant Mr. George AdamsAddress 327 Willard Ave, Chesapeake, Md.17. Burial Date thereof 6/12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington Nat. CemLocation Un18. Funeral director S. H. King Co.Address 2901-14th St. N. W. D. C.19. 6/10 46 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 46 at 10<sup>00</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/19 18 44 to present 19  
and that I last saw him alive on 6/10/46 19

Immediate cause of death

Cerebral embolism

DURATION

Due to myocardial infarctionDue to Coronary thrombosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Irving L. Marks, M.D. M. D. or otherAddress 4601 Leland St. Date signed 6/10/46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DEATH OF \_\_\_\_\_

DEATH CERTIFICATE

RECEIVED  
JUN 15 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

C6082

## CERTIFICATE OF DEATH

Reg. Dist. No.

217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Parkersburg  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Minnie Armstrong

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Leban B. Armstrong

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 11, 1877

8. AGE:

Years

Months

Days

If less than one day

6933

hrs.

min.

9. Birthplace

Garrett County, Md.  
(town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

Abraham Miller

13. Birthplace

Garrett Co. Maryland

MOTHER

14. Maiden name

Rebecca Wiley

15. Birthplace

Garrett Co. Maryland

16. Informant

Hospital Records

Address

17. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

Burial

Date thereof

6 16 46  
(month) (day) (year)

Cemetery or crematory

Rockville Md.

Location

Rockville Md.

18. Funeral director

Ray G. Boucher

Address

Laytonville Md.

19. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

June 16 1946

19. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

Esther B. Lawler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 14 19 46 at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 6 19 46 to JUNE 14 19 46and that I last saw her alive on JUNE 14 19 46

Immediate cause of death

Acute Coronary Thrombosis

DURATION

8 days

Due to

Due to

Other conditions

Chronic MyocarditisUndetermined

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David Allen

M. D.

Address

Olney Md.Date signed 6/14/46

RECEIVED

JUN 25 1946

BUREAU U S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 734

06083

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 19 Days  
Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 19 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Alabama County \_\_\_\_\_  
City or town Jasper  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

BANKHEAD, John Hollis Jr. Senator

### 3. (b) Social Security Number

4. Sex male 5. Color or race W- US 6.(a) Single, married, widowed, or divorced married  
B.(b) Name of husband or wife Mrs. Musa Bankhead  
7. Birth date of deceased (mo., day, yr.) 8 July 1872 6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 73 Months 11 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Alabama  
(Town, county, and state)  
10. Usual occupation Senator  
11. Industry or business \_\_\_\_\_  
12. Name John Hollis Bankhead Sr.  
13. Birthplace South Carolina  
14. Maiden name Talulah Brockman  
15. Birthplace Alabama

16. Informant Mrs. Musa Bankhead  
Address Jasper, Alabama  
17. removal Date thereof 6-12-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Oak Hill Cemetery  
Location Jasper, Alabama

18. Funeral director Joseph Gayler USF  
Address 1756 Penn. Ave. N.W. Wash., D.C.  
19. 12 June 1946  
(Date rec'd by registrar) Mary Charlotte Smith  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12 June 1946 at 4:15 p.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 May 1946 to June 12 1946  
and that I last saw him alive on 12 June 1946

Immediate cause of death Branchopneumonia DURATION 2 days  
Due to Cerebral Thrombosis 19 days  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE C. L. ANDREWS, Capt. (MC) USN M. D. or other \_\_\_\_\_  
Address USNH BETHESDA, MD. Date signed 6-12-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

6/17/46

RECEIVED

JUN 24 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITHOUT UNFADING INK. Supply every item of information carefully. The correct age of age of deceased is shown on

Evidence for the change of age of deceased is shown on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 957

06684

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

FILE No. I 04 JUN 24 1946

## 1. PLACE OF DEATH:

County MontgomeryCity or town Poolesville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 64

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Poolesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

James Maurice Beall

## 3.(b) Social Security Number

212145875

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Margaret Beall

7. Birth date of deceased (mo., day, yr.)

1884

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

62

Months

11/1944

Days

5

It less than one day

hrs.

min.

9. Birthplace

Poolesville, Mont. Co. Md  
(Town, county, and state)

10. Usual occupation

Teacher (School)

11. Industry or business

James Beall

MOTHER FATHER

12. Name

Md.

13. Birthplace

Catherine Morrison

14. Maiden name

Md.

15. Birthplace

16. Informant

Margaret Beall

Address

17. Burial

(Burial, cremation, or removal. Which?)

Monocopy

Date thereof

1884

Cemetery or crematorium

Beallsville, Md

Location

18. Funeral director

William B. Dillman

Address

Poolesville, Md

19. Date rec'd by registrar

June 17 46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 - 1946 at 10:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/15 - 1946 to 6/15 - 1946and that I last saw him alive on June 7 - 1946

Immediate cause of death

Organic Heart Disease

DURATION

5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Byron D. White, M.D.

M. D. or other

Address Poolesville, Md Date signed 6/16/46

RECEIVED

JUN 19 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

06085

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County MontgomeryCity or town German town, Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County MontgCity or town Poolesville, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Robert H. Blerins

## 3. (b) Social Security Number

214-18-6884

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

9. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 1888 5

8. AGE:

Years 58 9 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace

Smith, Va  
(Town, county, and state)

10. Usual occupation

Horse Trainer

11. Industry or business

MOTHER FATHER

12. Name

Henry Blerins

13. Birthplace

Va

14. Maiden name

Fronie Wassum

15. Birthplace

Va

16. Informant

Beebe Waddle

Address

German town, Md17. Burial  
(Burial, cremation, or removal. Which?)Burial Date thereof 6/10/46  
(month) (day) (year)

Cemetery or crematory

Monocacy

Location

Poolesville, Md

18. Funeral director

William B. Hilton

Address

Barnesville, Md

19. Date rec'd by registrar

June 9 1946 Mrs. C.C. Hilton

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 46, at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 19 46, to June 6 19 46and that I last saw him alive on June 4 19 46

Immediate cause of death

Pulmonary Tuberculosis

DURATION

unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Albert K. Johns  
Poolesville, Maryland

M. D. or other

Date signed June 7 1946

RECEIVED

JUN 19 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

## CERTIFICATE OF DEATH



Reg. Dist. No.

06086

223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution?

9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 404 Flower Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Samuel E Broomall

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Annie C Broomall

7. Birth date of deceased (mo., day, yr.)

July 14, 18696. (c) If alive, give age 75 years

8. AGE:

Years

Months

Days

If less than one day

76116

hrs.

min.

9. Birthplace

Chester County, Pennsylvania  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

JOHN BROOMALL

13. Birthplace

PHOENIXVILLE PA

14. Maiden name

HANNAH SHERER

15. Birthplace

PHOENIXVILLE PA.

16. Informant

Washington Sanitarium Records

Address

Takoma Park, Maryland

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

June 22-1946  
(month) (day) (year)

Cemetery or crematory

Location

Wilmington Del.

18. Funeral director

Arthur Walters

Address

254 Landon St. Takoma Park

19.

June 20 46

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1946 at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 111946, toJune 201946and that I last saw him alive on June 19 1946

Immediate cause of death

Aspiratory pneumonia  
(Bilateral lobar)

DURATION

4 days

Due to

Anesthetic - general

Due to

Prostatic Hypertrophy

Other conditions

Arterial Hypertension  
(Include pregnancy within 3 months of death)

Major findings of operations

Prostatic HypertrophyDate of op. 6/17/46

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Brown, Registrar

M. D. or other

Address

Potomac ParkDate signed 6/20/46

GAS CONTENT

RECEIVED  
JUN 22 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

06087

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hosp.How long in hospital or institution? June 15 - June 17, 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State TENNESSEE County HAWKINS  
 City or town SNEEDSVILLE  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(c) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Vesta Bryant

## 3.(b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife William Bryant  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 15, 1886  
 8. AGE: Years 60 Months 1 Days 2 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Sneedsville, Tennessee  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

FATHER 12. Name Earn Johnson13. Birthplace TennesseeMOTHER 14. Maiden name Pollie Hurley15. Birthplace Tennessee16. Informant Hospital RecordsAddress Olney, Maryland

17. Burial Date thereof June 19, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory SneedsvilleLocation Sneedsville, Hawkins Co., Tenn.18. Funeral director Warner E. PumphreyAddress Silver Spring, Md.

19. June 19, 1946 Date rec'd by registrar  
Leah B. Lawler Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17/1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/17/1946 to 6/17/1946  
 and that I last saw him alive on 6/17/1946

Immediate cause of death Acute Myocardial Infarction DURATION 2  
hrs.

Due to acute cardiac infarction 4 hours

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations none Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE km B M. D. or other \_\_\_\_\_

Address Sandy Spring, Md. Date signed 6/17/46

Permit issued by Silver Spring Registrar

RECEIVED  
JUN 25 1941  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(64)

06088

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

12 hours.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. #4  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Bertha Estelle Burriss

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 19468. AGE: Years Months Days If less than one day  
2 27 hrs. min.9. Birthplace Olney, Montgomery County, Maryland  
(Town, county, and state)10. Usual occupation Ex. art

11. Industry or business

12. Name Aubrey Burriss13. Birthplace Layhill, Maryland14. Maiden name Lucille King15. Birthplace Layhill, Maryland16. Informant Hospital records

Address

17. Burial Date thereof 6-18-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Layhill Church Cens.Location Layhill, Md18. Funeral director John RumberAddress Rockville, Maryland19. June 18 1946 Estelle Burriss Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1946 at 5:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1946 to June 16 1946and that I last saw her alive on June 16 1946

Immediate cause of death

Stasis Symptomatic 13 hrs

DURATION

Due to (Septicemia) Thymus 2 1/2 mo

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Layhill, Md Date signed 6/16/46

RECEIVED

JUN 25 1946

BUREAU U S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

06089

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney Md. Rural  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 10 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Olney Md. Rural  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Charles Greenbury Butler

## 3. (b) Social Security Number

214-16-7019

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Married.6. (b) Name of husband or wife Mary Ellen Butler7. Birth date of deceased (mo., day, yr.) Feb 3 - 1908 6. (c) If alive, give age years8. AGE: Years Months Days If less than one day  
38 3 29 hrs. min.9. Birthplace Montgomery Co Md  
(Town, county, and state)10. Usual occupation Road Laborer

11. Industry or business

12. Name Mary Ellen Butler13. Birthplace Montgomery Md.14. Maiden name Elizabeth Butler15. Birthplace Montgomery Md.16. Informant Mary Ellen ButlerAddress Olney Md17. Burial Date thereof 6/3/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BrookstoneLocation Brookstone Md.18. Funeral director Raymond BarberAddress Laytonville Md.19. 6-3- 46 Bertinda B. Lawler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1/46 1946 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to 1946and that I last saw h. alive on 1946Immediate cause of death Fracture dislocation of spine DURATION 45 min.Due to Fracture of spineDue to Fracture of spine

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy result Multiple coronary atherosclerosis & heart failure

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/1/46Where did injury occur? Olney Montgomery Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public HighwayMeans of Injury Hit by automobile Injured at work? No23. SIGNATURE Dr. B. M. C. Officer M. D. or otherAddress Sandy Spring Md. Date signed 6/1/46

RECEIVED  
JUN 10 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

06090

Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County Montgomery County  
 City or town Bethesda, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr. 10 mo. 5 days  
 Hospital, institution, or street address where death occurred:  
Washington San'y Hospital  
 How long in hospital or institution? 1 yr. 10 mo. 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State California County Glendale  
 City or town Glendale, California  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 226 Lincoln Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Mrs. Mary R. Calvert  
 4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John Marie Calvert

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec. 25-18728. AGE: Years 74.3 Months 5 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Bethesda, Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Charles W. Read13. Birthplace Bedford, Indiana14. Maiden name Sarah Alice Shriver15. Birthplace Maryland16. Informant Washington Sanatorium FundsAddress To Home Port, Maryland17. Burial, cremation, or removal. Which? Burial Date thereof June 9, 1946  
(month) (day) (year)Cemetery or crematory George Washington MemorialLocation Riggs Rd., R. Geo. Co., Md.18. Funeral director Warner E. PumphreyAddress Silver Spring, Md.19. June 9 1946  
(Date rec'd by registrar)

Registrar

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1946, at 9:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1944 to June 7 1946and that I last saw him alive on June 7 1946Immediate cause of death arteriosclerotic heart disease DURATION 14 yrsapical infarction sublemonDue to cerebral infarctionmyocardial failure

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations 0Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

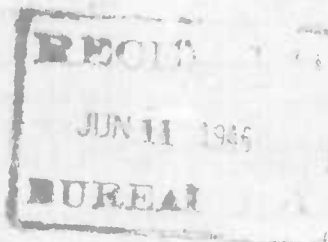
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Ch. M. J. Holder M.D.Address 500 Indiana St. N.W. Date signed 6/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore 940

# CERTIFICATE OF DEATH

★06091

Reg. Dist. No. 216

1. PLACE OF DEATH: County <u>Montgomery</u> City or town <u>Bethesda, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Dead on arrival</u> Hospital, institution, or street address where death occurred: <u>8600 Old Georgetown Rd.</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Montg. Co.</u> City or town _____ (If outside city or town limits, write RURAL and give nearest town) Street No. <u>117 Wash. Blvd. District Hyts. Md.</u> (If rural, give LOCATION) 2.(a) If veteran, name war _____			
3. (a) FULL NAME <u>MR. JAMES HENRY CARTER</u>				3. (b) Social Security Number _____			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>Bertie Virginia</u>				6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>Nov. 2, 1869</u>							
8. AGE: Years <u>76</u>		Months <u>7</u>		Days <u>12</u>		If less than one day _____ hrs. _____ min.	
9. Birthplace <u>Poolesville, Maryland</u> (Town, county, and state) <u>Retired</u>							
10. Usual occupation _____							
11. Industry or business _____							
12. Name <u>William Taylor Carter</u>							
13. Birthplace <u>Maryland</u>							
14. Maiden name <u>Amenda Davis</u>							
15. Birthplace <u>Virginia</u>							
16. Informant <u>Mr. Herbert L. Carter, Son</u>							
Address <u>Burial</u>							
17. (Burial, cremation, or removal. Which?) <u>6/17/46</u> (month) (day) (year) Cemetery or crematory <u>Mt. Pleasant Church Cem</u> Location <u>Taylorstown, Virginia</u>							
18. Funeral director <u>W. Reuben Humphrey</u>							
Address <u>7557 Wis. Ave. Bethesda, Md.</u>							
19. <u>6/17, 1946</u> <u>Wm E Jones</u> (Date rec'd by registrar) Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>June 14, 1946</u> 19____ at _____ M. 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from _____ and that I last saw him _____ alive on _____ 19____ Immediate cause of death <u>Coronary occlusion</u> DURATION <u>1 day</u> Due to _____ Due to _____ Other conditions _____ (Include pregnancy within 8 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ 23. SIGNATURE <u>E. G. Bauersfeld</u> M.D. or other _____ <u>Mont. Co.</u> Address <u>Bethesda, Md.</u> Date signed <u>6/15/46</u>							

CERTIFICATE OF DEATH

RECEIVED

JUN 24 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

06092

## CERTIFICATE OF DEATH



Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Germananton J.C.R. 2 J  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Germananton  
 (If outside city or town limits, write RURAL and give nearest town)  
R.F.D.  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John W. Case

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 15 1873  
 8. AGE: Years 73 Months 0 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 1873 73 0 25

9. Birthplace Monty Co. Md.  
 (Town, county, and state)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name Richard Case

13. Birthplace md.

14. Maiden name Mary Pedutis

15. Birthplace md.

16. Informant Mrs. Nicholas Harding

Address Germananton md.

17. Burial Date thereof 6/11/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Gaithersburg md.

18. Funeral director D.C. Gortner

Address Gaithersburg md.

19. June 10 19 46 Abdul G. Cooke  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 46 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Exam Case 19 \_\_\_\_\_ to 19 \_\_\_\_\_

and that I last saw him alive on 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

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## DURATION

2 months  
dead

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06093

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since June 23, 1946  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
 How long in hospital or institution? 1+ hour

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State No. Carolina County Gaston  
 City or town Gaston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 501 W. 2nd Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ☒

## 3. (a) FULL NAME

Fred. A. Cathey.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Myrtle Cathey.  
 6. (c) If alive, give age 60 years  
 7. Birth date of deceased (mo., day, yr.) 2-28-1883  
 8. AGE: Years 63 Months 3 Days 26 It less than one day  
 hrs. min.

9. Birthplace Gaston County, No. Carolina  
 (Town, county, and state)

10. Usual occupation Book Keeper.

## 11. Industry or business

MOTHER FATHER  
 12. Name not information  
 13. Birthplace not available  
 14. Maiden name  
 15. Birthplace

16. Informant Washington Sanitarium Hospital Records  
 Address Takoma Park Maryland.

17. removal Date thereof June 26, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory  
 Location Washington DC

18. Funeral director John Lewis Sons  
 Address 1756 Penn ave. N.W.

19. June 26, 1946 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1946 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-26 19 46, to 6-26 19 46, and that I last saw him alive on 6-26 19 46.

Immediate cause of death Cerebral hemorrhage

Due to arteriosclerosis DURATION 1 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel M. Bageant M.D.  
 Address Wash. DC. Date signed 6/26/46

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JUL 6 1946  
BUREAU 8



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JUL 2 1946  
BUREAU V E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1784

## CERTIFICATE OF DEATH

\* 06095

Reg. Dist. No. 316

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

4803 Hampden Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4803 Hampden Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Margaret Y. Clayton

## 3. (b) Social Security Number

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife Captain George Duell  
Clayton7. Birth date of deceased (mo., day, yr.) January 19, 19168. AGE: Years 30 Months 4 Days 26 If less than one day  
..... hrs. .... min.9. Birthplace Detroit Michigan  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Capt. George D. ClaytonAddress 4803 Hampden Lane, Bethesda 14, Md.17. Burial Date thereof 6/19/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington Natl. Cem.Location Arlington, Va.18. Funeral director Wm Reuben HumphreyAddress Bethesda, Maryland19. 6/17 19 46 Registrar Wm E Jones  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 46, at 10:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to June 1946 and that I last saw him alive on June 1946

Immediate cause of death

DURATION

Myocardial infarction  
Due to arteriosclerosis  
(accidental)  
homeOther conditions Heart dilatation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 6-15-46Where did injury occur? Bethesda Montg md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank L. Brochant M.D. M. D. or otherAddress 4803 Hampden Lane Date signed 6-16-46

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD NO. 100-100000

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JUN 19 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

06096

716

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery  
 County Frederick  
 City or town Ship Hights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 years  
 Hospital, institution, or street address where death occurred:  
127 Prospect Street  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Friendship Hights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 127 Prospect Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME Nellie Augusta Colby

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 19 - 1868 6.(c) If alive, give age ..... years

8. AGE: Years 78 Months 0 Days 3 It less than one day ..... hrs. .... min.

9. Birthplace Danville - Vermont  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Oscar Newell Colby

13. Birthplace Vermont

MOTHER 14. Maiden name August French Preston

15. Birthplace Vermont

16. Informant Miss S.P. Colby (Sister)  
 Address 127 Prospect St Friendship Hts

17. Shipment Date thereof 6/23/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Danville - St.  
 Location N. W. Nash Co.

18. Funeral director W. H. Nash Co.  
 Address 2901-14th St. N.W. Wash DC

19. 6/22 19 46 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 19 46 at 1:54 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1:30 - 1946 to June 22 - 1946

and that I last saw her alive on June 22 19 46

Immediate cause of death Arterio Sclerosis

Due to Generalized

Due to Arterial changes to age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Alphonse King MD

Address 1835 Eye St NW Washington DC Date signed 6-22-46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 27 1946

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06097

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 31 hours and 6 min.

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 31 hours and 6 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County WashingtonCity or town 2117 - 24th St. S.E.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2117 - 24th St. S.E.  
(If rural, give LOCATION)

2.(a) If veteran, name War

## 3. (a) FULL NAME

Baby boy Cox

## 3. (b) Social Security Number

4. Sex Male 5. Color or race cauc. 6. (a) Single, married, widowed, or divorced Infant

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 25, 19468. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Takoma Park, Montgomery Co., Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Edward Claggett Cox13. Birthplace Washington, D.C.MOTHER 14. Maiden name Mary Agnes Williamson15. Birthplace Accotink, Virginia16. Informant Records - Washington Gen. Hosp.Address Takoma Park, Md.17. Removal. Date thereof 6-27-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director W. W. Chambers Co.Address 517-11th St. S.E. Wash. D.C.19. 6/27/46 19. 46  
(Date rec'd by Registrar) (Date signed by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 19 46 at 3:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27-26 19 46 to June 27 19 46and that I last saw him alive on June 26, 1946 19 46Immediate cause of death Premature c  
Atelectasis

## DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jordan M. Hone M. D. or otherAddress 901 - 20th NW Date signed 6-27-46

RECEIVED  
JUL 6 1946  
BUREAU V.A.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1178)

## CERTIFICATE OF DEATH

06098

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 hours  
Hospital, institution, or street address where death occurred:  
US NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution? 2 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County Prince William  
City or town Quantico  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Quantico  
(If rural, give LOCATION) Quantico  
2(a) If veteran, name war Quantico

### 3. (a) FULL NAME

CULLEY, Aaron Levi

### 3. (b) Social Security Number

4. Sex male  
5. Color or race colored  
6. (a) Single, married, widowed, or divorced  
6. (b) Name of husband or wife  
6. (c) If alive, give age 19 1/4 years  
7. Birth date of deceased (mo., day, yr.) unknown 1914  
8. AGE: Years 32 Months Days If less than one day hrs. min.

9. Birthplace Va.  
(Town, county, and state)  
10. Usual occupation veteran  
11. Industry or business  
12. Name John Culley  
13. Birthplace Va.  
14. Maiden name Ida  
15. Birthplace Va.

16. Informant Fa: Mr. Father Culley  
Address Quantico, Va.  
17. burial Date thereof 6-20-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Va.  
18. Funeral director Ernest W. Jarvis  
Address 1432 U St., N.W., Wash., D.C.  
Mary Charlotte Smith  
19. 17 June 46 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 17 June 46 at 5:20 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 June 46 to 17 June 46  
and that I last saw him alive on 17 June 46  
Immediate cause of death Ulcer, duodenal, ruptured  
peritonitis generalized DURATION 12 hrs  
Due to  
Due to  
Other conditions  
(Include pregnancy within 8 months of death)  
Major findings of operations Ruptured duodenal ulcer & peritonitis Date of op. 18 June 46  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Frank S. Ashburn Lt. Comdr. (M) USN  
Address USNH Bethesda, Md. Date signed 6-17-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6/26/46

RECEIVED

JUL 3 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06099

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 56 minutes  
 Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 56 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County D.C.  
 City or town Washington, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6629 First St. N.W., Wash., D.C.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war                     

## 3. (a) FULL NAME

DAGER, William Frederick

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Lillian J. Dager  
 6. (c) If alive, give age                      years  
 7. Birth date of deceased (mo., day, yr.) 1 Feb. 1873  
 8. AGE: Years 73 Months 4 Days 0 If less than one day                      hrs.                      min.

9. Birthplace Canada  
 (Town, county, and state)  
 10. Usual occupation Physician (retired)  
 11. Industry or business                     

FATHER 12. Name Daniel Dager  
 13. Birthplace Canada (dec)  
 MOTHER 14. Maiden name Caverhill  
 15. Birthplace Canada (dec)

16. Informant Mrs. Lillian J. Dager  
 Address 6629 First St. N.W. Wash., D.C.  
 17. burial Date thereof 6-5-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Virginia

18. Funeral director S.H. Hines S.H.H.O.  
 Address 2901 14th St. N.W. Wash., D.C.  
 19. 2 June 1946 Mary Charlotte Smith  
 (Date rec'd by registrar) (Year) (Name of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 June 19 46 at 11:56p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 June 19 46 to 1 June 19 46  
 and that I last saw him alive on 1 June 19 46

Immediate cause of death Acute Congestive Failure due to Thrombosis  
Coronary

## DURATION

6 hrsDue to                     Due to                     Other conditions                     

(Include pregnancy within 3 months of death)

Major findings of operations                     Date of op.                     Autopsy results Thrombotic Coronary artery

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide                      Date of                     Where did injury occur?                      (City or town) (County) (State)Injured at home, farm, industry, public place (where?)                     Means of injury CW Thump Injured at work?                     23. SIGNATURE C. W. THOMPSON, Lt. Cdr. (MC) USNRM. D. or other                     Address USNH Bethesda, Md. Date signed 6-2-46

RECEIVED  
JUN 10 1966  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

06100

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural Lewisdale Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed or divorced Widowed8. (b) Name of husband or wife Rosa B. Day7. Birth date of deceased (mo., day, yr.) 1861 Aug. 4 6. (c) If alive, give age - years8. AGE: Years 84 Months 10 Days 3 If less than one day - hrs. - min.9. Birthplace Lewisdale Md (Town, county, and state)10. Usual occupation Retired Farmer11. Industry or business Farm12. Name James W. Day13. Birthplace Montgomery Co Md14. Maiden name Sarah Beall15. Birthplace Montgomery Co Md16. Informant J. Beall DayAddress Monrovia Md17. Burial Date thereof June 10, 1946

(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Bethesda MdLocation Brownsville Md18. Funeral director Ray W. BarkerAddress Lanhamville Md19. June 8, 1946 Della W. Burdette

(Type rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rural Lewisdale Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. -  
(If rural, give LOCATION)2. (a) If veteran, name war -3. (b) Social Security Number -

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 13, 1943 to June 7, 1946and that I last saw him alive on June 6, 1946Immediate cause of death Arteriosclerosis

## DURATION

10 yearsDue to -Due to -Other conditions Cerebral hemorrhage Mar 13, 1943

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Ernest P. Roop, M.D. M. D. or otherAddress New Market, Md Date signed June 7, 1946

RECEIVED  
JUN 11 1946  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 06101  
Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County... Montgomery  
City or town... Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 13 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District of Columbia County... -

City or town... Takoma Park Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 345 Cedar St.  
(If rural, give LOCATION)

2.(a) If veteran, name war... ✓

## 3. (a) FULL NAME

MRS. MATTIE DEGGES

## 3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Mr. William J. Degges

- (Deceased) -

7. Birth date of deceased (mo., day, yr.): May 3, 1859

6.(c) If alive, give age... years

8. AGE: Years: 87 Months: one(1) Days: 21 If less than one day

hrs. min.

9. Birthplace: Harrisonburg, Virginia

(Town, county, and state)

10. Usual occupation: Boarding house keeper

11. Industry or business: " " "

12. Name: George Bealor13. Birthplace: Virginia14. Maiden name: Isabel (?) surname unknown15. Birthplace: Virginia16. Informant: Records-Washington Sanitarium & HospitalAddress: 700 Carroll Avenue, Takoma Park, Maryland17. Burial Date thereof: June 27, 1946

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory: Glenwood CemeteryLocation: Lincoln Road N.E.18. Funeral director: Robert WalkerAddress: 254 Carroll St., D.C.19. June 25, 46

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 June 1946 at 10<sup>59</sup> am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11 June 1946 to 24 June 1946

and that I last saw him... alive on... 19...

Immediate cause of death:

Congestive heart failureDURATION: 1 moDue to: Chronic heart diseasewith mitral stenosis &coronary insufficiencyOther conditions: Senility

(Include pregnancy within 3 months of death)

Major findings of operations: no operation

Date of op.:

Autopsy results: no autopsy permitted

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William J. Brown, M.D.Address: 45 Carroll Ave, Takoma ParkDate signed: 24 June 46

RECEIVED  
JUN 27 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19/2

## CERTIFICATE OF DEATH

06102

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Sandy Spring MD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Fifty Years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland. County..... Monty.  
 City or town..... Sandy Spring MD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... NO

## 3. (a) FULL NAME

Harry S. Easton

## 3. (b) Social Security Number

no

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, or divorced..... Married  
 6.(b) Name of husband or wife..... Carrie S. Easton  
 6.(c) If alive, give age..... 70 years  
 7. Birth date of deceased (mo., day, yr.)..... Nov. 13. 1865  
 8. AGE: Years..... 80 Months..... 7 Days..... 4 It less than one day..... hrs. .... min.

9. Birthplace..... Brookeville MD.  
 (Town, county, and state)  
 10. Usual occupation..... Retired Miller  
 11. Industry or business..... Mill

12. Name..... William Easton  
 13. Birthplace..... Sandy Spring MD.  
 14. Maiden name..... Margaret Easton  
 15. Birthplace..... Scotland

16. Informant..... Mrs. Carrie S. Easton  
 Address..... Sandy Spring MD.

17. Burial Date thereof..... June 19 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Friends  
 Location..... Sandy Spring MD.

18. Funeral director..... Roy W. Barber  
 Address..... Laytonsville MD.

19. June 19 1946 Ge. Tucker B. Barber  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 6/17/1946 at..... 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan 1..... 19..... 46, to..... 6/17/1946  
 and that I last saw him..... alive on..... 6/16/1946..... 19..... 46

Immediate cause of death..... uræmia  
 DURATION..... 4 days

Due to..... Chronic Interstitial nephritis  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)  
 Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?.....

23. SIGNATURE.....  
 M. D. or other  
 Address..... Date signed.....

RECEIVED

JUN 25 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 06103

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_  
 City or town Washington, D. C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 801 P St., N. W., Apt. #130  
 (If rural, give LOCATION) ★  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

EVANS, Edward Godfrey

## 3. (b) Social Security Number

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 15 July 1871 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 74 Months 10 Days 27 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)

10. Usual occupation veteran

11. Industry or business \_\_\_\_\_

12. Name Henry Evans13. Birthplace Wash., D.C.14. Maiden name Caroline Scott15. Birthplace Wash., D.C.16. Informant Mrs. Elizabeth JacksonAddress 801 "P" St. N.W. Washington, D.C.

17. burial Date thereof 6-15-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Harmony CemeteryLocation Rhode Island Avenue, N.E., Wash., D.C.18. Funeral director Ernest W. JARVIS JR.Address 1432 U St., N. W., Wash., D.C.

19. 6-12 46  
 (Date rec'd by registrar) Registrar Mary Charlotte Smith

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 June 1946 at 4:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 June to 12 June and that I last saw him alive on 12 June

Immediate cause of death Arteriosclerosis, Generalized DURATION Indef

Due to Arterial hypertension Indef

Other conditions Bronchopneumonia Recent Indef.

Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. B. SHULER, Comdr. (MC) USN  
 M. D. or other \_\_\_\_\_

Address USNH, Bethesda, Md. Date signed 6-12-46

RECEIVED

JUN 24 1946

BUREAU T S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06104

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

4823 Rugby Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4823 Rugby Ave.

(If rural, give LOCATION)

No

2.(a) If veteran, name war

## 3. (a) FULL NAME

WILLIAM DAVID EVANS

## 3. (b) Social Security Number

403-16-2471

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Married</u>

8.(b) Name of husband or wife Della H.6.(c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) May 25, 1885

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>1</u>	<u>24</u>	.....hrs. ....min.

9. Birthplace Kentucky  
(Town, county, and state)10. Usual occupation Salesman

11. Industry or business

FATHER	12. Name	<u>Robert B. Evans</u>
	13. Birthplace	<u>Kentucky</u>

MOTHER	14. Maiden name	<u>Mary Wade</u>
	15. Birthplace	<u>Kentucky</u>

16. Informant Mrs. Della H. EvansAddress 4823 Rugby Ave.17. Burial Date thereof 6/21/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rockville Union CemeteryLocation Rockville, Maryland18. Funeral director W. R. HumphreyAddress 7557 Wis. Ave. Bethesda, Md.19. 6/19 1946 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1946 19..... at 6:50 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945 to June 18, 1946and that I last saw him alive on June 18, 1946

Immediate cause of death

acute congestive heart failure

DURATION

1 weekDue to Chronic endocarditis

DUE TO

5 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. BancroftAddress Bethesda, Md. Date signed 6/19/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 27 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06105

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, Rt. 3  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Burdett Rd. - Rt. 3  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

Jessie Watt Fisher

## 3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED  
 6. (b) Name of husband or wife Thomas Daeg Fisher  
 7. Birth date of deceased (mo., day, yr.) December 10, 1890 8. (c) If alive, give age 62 years  
 8. AGE: Years 55 Months 6 Days 5 If less than one day  
 hrs. min.

9. Birthplace Scotland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name Archibald Watt  
 13. Birthplace Scotland  
 14. Maiden name Margaret Miller  
 15. Birthplace Scotland

16. Informant Thomas Daeg Fisher (husband)  
 Address Rt. 3-Burdett Rd. - Bethesda, Md.  
 17. Cremation Date thereof June 19, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location Washington, D.C.  
 18. Funeral director Wm. Reuben Humphrey  
 Address Bethesda, Maryland  
 19. 6/17 19 46  
 (Date read by registrar) Registrar Wm. E. Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 46 at 6:00 P.M.  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 1, 1945 to June 15, 1946  
 and that I last saw her alive on June 15, 1946  
 Immediate cause of death Carcinoma of Liver DURATION 8 mo.  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE E. G. Bowersfield Jr. M. D. or other  
 Address Bethesda, Md. Date signed 6/17/46

UNITED STATES DEPARTMENT OF HEALTH

RECEIVED

RECEIVED

JUN 24 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191-20

## CERTIFICATE OF DEATH

06106

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4711 Harrison St.  
(If rural, give LOCATION)2.(a) If veteran, name war... No

## 3. (a) FULL NAME

MR. CHARLES A. GRIGGS

## 3. (b) Social Security Number

NONE

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife... Luella C. Griggs6.(c) If alive, give age 79 years  
deceased (mo., day, yr.) January 19, 1865

## 8. AGE:

Years

Months

Days

If less than one day

81

4

28

.....hrs. ....min.

9. Birthplace... Gallupville, N.Y.  
(Town, county, and state)10. Usual occupation... Retired farmer11. Industry or business... Farming12. Name... Gidon V. Griggs13. Birthplace... Schoharie, N.Y.14. Maiden name... Christiana M. Young15. Birthplace... Schoharie, N.Y.16. Informant... Mrs. Wm. Lathan Rickard (daughter)Address... 4711 Harrison St., Chevy Chase, Md.17. Shipment Date thereof... June 19, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Old Stone Fort CemeteryLocation... Schoharie, N.Y.18. Funeral director... W. Keith ThompsonAddress... Bethesda, Maryland19. 6/18 1946 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 17 19 46 at 4:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Mar 1 19 37 to June 17 19 46  
and that I last saw him alive on June 17 19 46Immediate cause of death... BronchopneumoniaDURATION  
2 daDue to... cardiovascular diseaseDURATION  
9 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE... E. E. Quayle M.D.Address... 1822 Baltimore St. N. Taber M. D. or other  
Date signed 6/18/46

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

OCCUPATION

DATE OF DEATH

DATE OF DEATH

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JUN 24 1946

FAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/2

## CERTIFICATE OF DEATH

06107

★ Reg. Dist. No. 2/3-

1. PLACE OF DEATH: *Montgomery*  
 County.....*Lanham*  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*5 years*  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*Maryland* County.....*Montgomery*  
 City or town.....*Lanham*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Aaron Halterman*

3. (b) Social Security Number

4. Sex *male* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *widowed*

6.(b) Name of husband or wife *Mary Cooper Halterman*  
*deceased* 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) *May - 21 - 1857*

8. AGE: Years *89* Months *0* Days *13* If less than one day  
 .....hrs. ....min.

9. Birthplace *Mathias, W. Va.*  
 (Town, county, and state)

10. Usual occupation *farmer*

11. Industry or business *farming*

FATHER 12. Name *Aaron Halterman*

13. Birthplace *Mathias, W. Va.*

MOTHER 14. Maiden name *Phoebe Yankee*

15. Birthplace *Criders Va*

16. Informant *Mollie Etta Wilkins*

Address *Lanham, Md*

17. *Burial* Date thereof *June 4, 1946*

(Burial, cremation, or removal. Which?) month (day) (year)

Cemetery or crematory *Bereton Church Cemetery*

Location *Bereton Va*

18. Funeral director *W. H. Chambers Co*

Address *5801 Cleveland, Thiersdale, Md*

6/3/46 *Josephine D. Trotter*

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May - June - 3 - 1946* at *6:10 A M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec - 22 - 1946* to *June - 3 - 1946*

and that I last saw *him* alive on *June - 3 - 1946*

Immediate cause of death.....

*cardio. neffinita* DURATION *3 months*

Due to.....

*Cerebral hemorrhage* *5 months*

Due to.....

Other conditions *organic dementia* *3 months*

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE *William C. Miller, M.D.*

Address *Gaithersburg, Md* Date signed *6/3/46*

M. D. or other

RECEIVED  
JUN 14 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(1242)

## CERTIFICATE OF DEATH

06108

216

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 hrs - 55 min.

Hospital, institution, or street address where death occurred:

Suburban Hosp. - Bethesda, Md.How long in hospital or institution? 5 hrs - 55 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4812 M. Lane  
(If rural, give LOCATION)2(a) If veteran, name war No

## 3. (a) FULL NAME

Mr. Wm. J. Hartley

## 3. (b) Social Security Number

215-26-04594. Sex m 5. Color or race w 6. (a) Single, married, ~~widowed~~, or divorced m6. (b) Name of husband or wife Frieda N. Hartley6. (c) If alive, give age 44 years7. Birth date of deceased (mo., day, yr.) 7-25-19988. AGE: Years 47 Months 10 Days 22 If less than one day hrs. min.9. Birthplace W. Virginia  
(Town, county, and state)10. Usual occupation mechanic

## 11. Industry or business

12. Name Charles M. Hartley13. Birthplace Fairmont, W. Va.14. Maiden name Nettie I. Reese15. Birthplace Fairmont, W. Va.16. Informant Mr. Robert W. Hartley (son)Address 104 Wootten Ave., Chevy Chase, Md17. burial Date thereof June 20, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rockville UnionLocation Rockville, Md.18. Funeral director Wm. Reuben HumphreyAddress Bethesda, Md.19. 6/19 19 46 Wm E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 19 46 at 9 55 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 46 to June 17 19 46 and that I last saw him alive on June 17 19 46Immediate cause of death Hemorrhage

## DURATION

12 hrs.Due to Esophageal varicesDue to acute alcoholic gastritis and cirrhosis of the liver

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Ruptured esophageal varices; cirrhosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Barbara Mueller MDAddress Bethesda, Md. Date signed June 19, 1946

50100

RECEIVED  
JUN 27 1946  
BUREAU V.S.

Evidence for the change of

age of deceased is shown on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22Q

06109

Reg. Dist. No. 216

FILM No. I O 6 JUL 17 1946

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1138 3rd St., N.W.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

HAY, Pete Johnson

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

married (separated)6. (b) Name of husband or wife Mrs. Maude Hay7. Birth date of deceased (mo., day, yr.) 2 April 1914

6. (c) If alive, give age years

8. AGE: Years 32 Months 31 Days 25 It less than one day  
hrs. min.9. Birthplace S.C.  
(Town, county, and state)10. Usual occupation Veteran

11. Industry or business

12. Name Cesar Hay13. Birthplace S.C. dec.14. Maiden name Dora Barker15. Birthplace S.C. dec16. Informant brother: Mr. Andrew HayAddress 1138 3rd St., N.W., Wash., D.C.17. removal Date thereof 6-28-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. LukesLocation Meyers Mill, S. C.18. Funeral director Ernest W. JarvisAddress 1432 U St., N. W., Wash. D. C.19. 6-27 46 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 27 June 19 46 at 9:05 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19 June 1946 to 27 June 1946  
and that I last saw him alive on 27 June 1946Immediate cause of death  
Military Tuberculosis  
Due to military Tuberculosis  
Due to  
Other conditions None  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Military Tuberculosis Date of op.  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?23. SIGNATURE W. A. DINSMOORE, Jr., Lt. Cdr. (MC) USN  
M. D. or other  
Address USNH Bethesda, Md. Date signed 6-27-46

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 6 1946  
BUREAU V S

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

06110

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 days  
 Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Washington, D.C. County Washington  
 City or town Washington, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1805 Ft. Davis St. S.E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

William Eugene HIGGSV.B.P.

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Edith Higgs  
 7. Birth date of deceased (mo., day, yr.) Oct. 16, 1893  
 6. (c) If alive, give age 52 years  
 8. AGE: Years 52 Months 8 Days 29 If less than one day hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Veteran  
 11. Industry or business  
 12. Name William  
 13. Birthplace Maryland  
 14. Maiden name Maud Burroughs  
 15. Birthplace Maryland

16. Informant Mrs. Edith Higgs  
 Address 1805 Ft. Davis St. S.E. Wash, D.C.  
 17. burial Date thereof 7-2-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director W.W. Chambers Co. ms  
 Address 517 11th St. S.E. Washington, D.C.  
 19. 29 June 19 46 Mary Charlotte Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 June 1946 at 6:30 a  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
25 June 1946 to 29 June 1946  
 and that I last saw him alive on 29 June 1946 1946  
 Immediate cause of death  
Cor pulmonale chronic  
 DURATION 1 year  
 Due to tuberculosis pericarditis  
 Due to pulmonary tuberculosis 5 years  
 Other conditions cirrhosis of the liver  
 (Include pregnancy within 3 months of death)

Major findings of operations as above Date of op.

Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE C. W. Thompson ms  
C. W. THOMPSON, Lt. Cdr. (MC) USNR  
 M. D. or other  
 Address USNH Bethesda, Md. Date signed 6-29-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/9/46

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JUL 10 1948

BUREAU V E

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 309

## CERTIFICATE OF DEATH

06111

Reg. Dist. No. 211

### 1. PLACE OF DEATH:

County Montgomery  
City or town Damascus Rural Mt Airy 5  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Ten years

### 3. (a) FULL NAME

Laura Beatrice Holsey

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Waldon E. Holsey

6 (c) If alive, give age 36 years

7. Birth date of

deceased (mo., day, yr.) May 12 - 1917

8. AGE:

Years 29 Months 1 Days 16 If less than one day  
hrs. min.

9. Birthplace

Howard (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

12. Name

Harrison B. Myers

13. Birthplace

Howard Col and

14. Maiden name

Waisy Myers

15. Birthplace

Carroll Co and

16. Informant

Waldon E. Holsey

Address

Mt Airy 5

17. Burial

(Burial, cremation, or removal. Which?) Interment Date thereof June 29, 1946 (month) (day) (year)

Cemetery or crematory

Friend Shipps road

Location

Damascus, Md

18. Funeral director

Prof W. Barber

Address

Springville, Md

19. Date rec'd by registrar

June 29, 1946 Lella W. Burdette Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery  
City or town Mt Airy Md 5 Ward No. 5  
(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2 (a) IF VETERAN, NAME WAR

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1946 at 6:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15, 1944 to June 27, 1946; and that I last saw him alive on June 28, 1946

Immediate cause of death

Hypertensive cardio-vascular disease

DURATION

2 years

Due to

Syphilis

15 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

James P. Kere M.D. M. D. or other

Address

Damascus, Md. Date signed 6/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

06112

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County D.C.  
 City or town Washington, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1911 Conn. Ave. Wash., D.C.  
 (If rural, give LOCATION) ★  
 2. (a) If veteran, name war ✓

## 3. (a) FULL NAME

Robert Morris KENNEDY R. Adm Ret. Inact.

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Bessie Kennedy  
 6. (c) If alive, give age 46 years  
 7. Birth date of deceased (mo., day, yr.) 21 June 1867  
 8. AGE: Years 79 Months 0 Days 26 If less than one day hrs. min.

9. Birthplace Penn.  
 (Town, county, and state)  
 10. Usual occupation U.S. Navy Retired  
 11. Industry or business

FATHER 12. Name George W. Kennedy  
 13. Birthplace Penna. (dec)  
 MOTHER 14. Maiden name Elizabeth Morris  
 15. Birthplace Penna. (dec)

16. Informant Mrs. Bessie Kennedy  
 Address 1914 Conn. Ave. Wash., D.C.  
 17. burial Date thereof 6-19-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director Joseph Gawler E.R.Y.  
 Address 1750 Penna. Aven., N.W., Wash., D.C.  
 19. 16 June 46  
 (Data rec'd by registrar) Registrar Mary Charlotte Smith

## MEDICAL CERTIFICATION

20. DATE OF DEATH 16 June 19 46 at 8:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-10 19 46 to 6-16 19 46  
 and that I last saw him alive on 6-16 19 46

Immediate cause of death Edema of lungs, acute DURATION 20 min.  
Coronary Heart Disease 11 years

Due to Coronary Heart Disease  
 Due to Discharge  
 Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Discharge  
 Date of op.

Autopsy results Discharge  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Discharge Date of Discharge  
 Where did injury occur? Discharge (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Discharge  
 Means of Injury Discharge Injured at work? Discharge

23. SIGNATURE H. I. Jones Jr. (MC) USN  
 M. D. or other Discharge  
 Address USNH Bethesda, Md. Date signed 6-16-46

RECEIVED  
JUN 27 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 197

06113

## CERTIFICATE OF DEATH

Reg. Dist. No. 253

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day - 16 hours - 52 minutes  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium and Hospital  
 How long in hospital or institution? 1 day - 16 hrs. - 52 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Sandy Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Box # 25  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Baby Boy Kernan

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhite—

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 10, 1946.8. AGE: Years Months Days If less than one day  
— — 1 16 hrs. 52 min.9. Birthplace Takoma Park, Montgomery, Maryland  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name John Thomas Kernan13. Birthplace Philadelphia, Pennsylvania14. Maiden name Helen May Brown15. Birthplace Sandy Spring, Maryland16. Informant Records - Washington Sanitarium and HospitalAddress 700 Carroll Avenue, Takoma Park, Maryland.17. Burial Date thereof June 14, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Geo. Wash. MemorialLocation Maryland18. Funeral director Arthur WaltersAddress 254 Carroll St. N. W. Wash. D.C.19. June 14, 1946  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 46 at 4:37 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 19 46 to June 12 19 46and that I last saw him alive on June 12 19 46

Immediate cause of death.....

Respiratory failure

DURATION

2 hours

Due to.....

Pneumatury2 months

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address 800 Woodbury Drive  
Sandy Spring, Md Date signed 6/2/46

RECEIVED

JUN 19 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (201)

## CERTIFICATE OF DEATH

06114

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Ashton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs. Sally Naomi Kaykendall

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MarriedB. (b) Name of husband or wife Mr. Ray Kaykendall

B. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

January 25, 1892

8. AGE:

Years

Months

Days

If less than one day

54426

hrs.

min.

539. Birthplace Asheville, North Carolina

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

Home

FATHER

12. Name

Dowell Norris

13. Birthplace

North Carolina

MOTHER

14. Maiden name

Jane Tyree

15. Birthplace

North Carolina16. Informant Hospital records

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 24, 1946

(month) (day) (year)

Cemetery or crematory

St. Carmel

Location

Shutlin and Montgomery Co. Md.

18. Funeral director

Ray W. Barber

Address

Ashtonsville, Md.19. 6-24 46

(Date rec'd by registrar)

19. 46Gertrude B. Fowler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1946, at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 15 1946, to JUNE 21 1946and that I last saw her alive on JUNE 21 1946Immediate cause of death Acute Paratyphoid DURATIONrephritis 4 daysDue to Acute appendicitis 8 days

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations acute appendicitisSerous peritonitis Date of op. 6-15-46

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Amelia M. D. or otherAddress Sandy Spring, Md. Date signed 6/22/46

RECEIVED

JUL 17 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

## CERTIFICATE OF DEATH

06115

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 8 hours, 20 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6810 Glenbrook Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Rita Fuquet Laws

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William K. Laws

7. Birth date of deceased (mo., day, yr.) October 16, 1899 8. (c) If alive, give age years

8. AGE: Years 46 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace New York, New York  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name Dallet Fuquet13. Birthplace New York, New York14. Maiden name Ella Geissel15. Birthplace New York, New York18. Informant William K. LawsAddress 6810 Glenbrook Rd., Bethesda, Md.17. Burial Date thereof 6/26/46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Lincoln CemLocation Wash. D.C.18. Funeral director Chas. Chase Funeral HomeAddress 5103 Wisconsin Ave., N.W., Wash. D.C.19. 6/22/46 18 46 Jm E Jones

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 46 at 3:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1943 19 46 to June 23 19 46and that I last saw her alive on June 23 19 46

Immediate cause of death Cerebral accident DURATION 9 hrs.

Due to Hypertension 3 yrs. +Due to (over)Other conditions (over)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

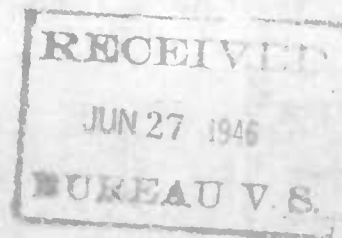
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Karl Fritzsch, M.D. M. D. or otherAddress 3130 Wis Ave. Date signed 6/23/46

Because patient was in hospital  
less than 24 hrs. - Coroner's  
office was notified and  
issue of certificate authorized.

K. Ditzler



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

06116

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 hours  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Va. County \_\_\_\_\_  
 City or town Falls Church  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_ (If rural, give LOCATION)  
 2(a) If veteran, name war World War I ✓

## 3. (a) FULL NAME

LEE, Louis Edward

## 3. (b) Social Security Number

4. Sex male 5. Color or race Col-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) 7 July 1888 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 57 Months 11 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Va.  
 (Town, county, and state)

10. Usual occupation veteran

11. Industry or business

12. Name James Lee13. Birthplace Va.14. Maiden name Lilly Carter15. Birthplace Va.16. Informant Mother: Mrs. Lilly Carter LeeAddress Falls Church, Va.

17. burial Date thereof 7-2 -46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director Ernest W. JarvisAddress 1432 U St., N. W., Wash. D.C.

19. June 28 1946 Mary Charlotte Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 27 June 1946 at 7:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
26 June 1946, to 27 June 1946  
 and that I last saw him alive on 27 June 1946

Immediate cause of death  
Cor pulmonale, chronic

Due to pulmonary fibrosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. THOMPSON, Lt. Cdr. (MC) USN

Address USNH Bethesda, Md. Date signed 6-28-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/9/46

RECEIVED

JUL 10 1946

BUREAU V. &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 113

## CERTIFICATE OF DEATH

06117  
Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Residence, institution, or street address where death occurred:

Meem Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. Meem Avenue  
(If rural, give LOCATION)2(a) If veteran, name war... no

## 3. (a) FULL NAME

JOSEPH AUBREY MILLS

## 3. (b) Social Security Number

212 10 3946

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

marriedB. (b) Name of husband or wife... Susie B.

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) April 23rd. 1891

8. AGE: Years Months Days If less than one day

55115

hrs. min.

9. Birthplace... Gaithersburg, Md.  
(Town, county, and state)10. Usual occupation... Carpenter

11. Industry or business

12. Name... Joseph Henry Mills13. Birthplace... Gaithersburg, Md.14. Maiden name... Emma Jane Snyder15. Birthplace... Montg. Co. Md.16. Informant... Mrs. Susie B. MillsAddress... Meem Ave. Gaithersburg, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof... 6 - 10 - 1946  
(month) (day) (year)Cemetery or crematory... Forest OakLocation... Gaithersburg, Md.18. Funeral director... Warner E. PumphreyAddress... Silver Spring, Md.19. Date rec'd by registrar... June 9 19... 46 Alfred G. Cooke  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 8 19... 46 at... 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8 19... 46 to June 8 19... 46and that I last saw him... alive on June 7 19... 46Immediate cause of death... acute cardiac dilatation

## DURATION

1/2 hr.Due to... emphysema2 yrs.

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... A. B. Burchart M.D.

M. D. or other

Address... Gaithersburg Md Date signed... 6-8-46

RECEIVED  
JUN 11 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

## CERTIFICATE OF DEATH

06118223  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Feb 12, 1946.  
 Hospital, institution, or street address where death occurred:  
Golliffe Nursing Home 805 Maple Ave.  
 How long in hospital or institution? Feb 12, 1946.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4913 - 1st St. N.W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war none

## 3. (a) FULL NAME

Ella Karns Mull

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife David O. Mull.  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Dec 11, 1865  
 8. AGE: Years 80 Months 6 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Franklin County, Ohio  
 (Town, county, and state)  
 10. Usual occupation Retired Homemaker  
 11. Industry or business \_\_\_\_\_  
 12. Name Karns  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace \_\_\_\_\_

16. Informant Orval B. Mull - Son  
 Address 4913 - 1st St N.W. Wash. DC  
 17. Removal Date thereof June 29 '46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Washington  
 Location \_\_\_\_\_

19. Funeral director The D. N. Jones Co  
 Address 2901-14 St N.W.  
 19. June 29 19 46 J. W. Dudley Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 June 19 46 at 4:30 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 April 19 46 to 29 June 19 46  
 and that I last saw him alive on 28 June 19 46  
 Immediate cause of death Fracture  
right hip  
 D. Arteriosclerosis, generalized  
 E. Pneumonia, terminal  
Broncho  
 Other conditions Hypertension, nodular  
 (Include pregnancy within 3 months of death)

## DURATION

2 mo.unknown1 dayunknown

Major findings of operations No operation other than application of cast Date of op. 23 April 46  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 14 April 46  
 Where did injury occur? Takoma Park, Montgomery, Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Nursing home  
 Means of injury Fall Injured at work? no

23. SIGNATURE William J. Brown, MD  
 Address 45 Carroll Ave, Takoma Park, Md. Date signed 29 June 46  
 M. D. or other

RECEIVED  
JUL 6 1946  
BUREAU 78

Evidence for change of age of deceased is shown on

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

06119

Reg. Dist. No. 218

FILM NO. I 06 AUG 23 1946

## 1. PLACE OF DEATH:

County Montgomery  
City or town Shiloh (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Shiloh (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

Wilbert G. Newman

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Mary L. Newman  
7. Birth date of deceased (mo., day, yr.) October 18, 1882 8. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 64 Months 63 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Redland, Maryland  
(Town, county, and state)  
10. Usual occupation Laborer

## 11. Industry or business

12. Name Albert Newman  
13. Birthplace va.  
14. Maiden name Mary Newman  
15. Birthplace va.

16. Informant Mary Newman (wife)  
Address Shiloh (R.F.D.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1, 1946  
(month) (day) (year)  
Cemetery or crematory Mt. Zion Church Cemetery  
Location Mt. Zion Maryland

18. Funeral director R. L. Snawden  
Address Rockville, Md.

19. June 30, 1946 (Date rec'd by registrar) Abraham G. Cook Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1946 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to 1946 and that I last saw him alive on June 28, 1946

Immediate cause of death \_\_\_\_\_ DURATION

Acute Cardiac  
Due to distention 3 hrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Joseph J. Boerhaas M.D.  
M. D. or other \_\_\_\_\_

Address Shiloh Md Date signed June 28, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 2 1946  
BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06120

Reg. Dist. No. 716

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 days  
Hospital, institution, or street address where death occurred:  
Suburban Hospital  
How long in hospital or institution? 3 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4700 Locust Hill Court  
(If rural, give LOCATION)  
2.(a) If veteran, name war No

### 3. (a) FULL NAME

MR. LUTHER NINE

### 3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Nevada D. Nine

7. Birth date of deceased (mo., day, yr.) March 10, 1878  
8. (c) If alive, give age 75 years

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>3</u>	<u>8</u>	.....hrs. ....min.

9. Birthplace Sunny Side, Md.  
(Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business Farming

12. Name Peter F. Nine

13. Birthplace Maryland

14. Maiden name Charolette Whitehair

15. Birthplace West Virginia

16. Informant Mrs. Jack Covington

Address 4700 Locust Hill Court  
Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 6/20/46  
(month) (day) (year)

Cemetery or crematory Oakland Cemetery

Location Oakland, Maryland

19. Funeral director Wm. Landon Humphrey

Address Bethesda, Maryland

19. 6/18 19 46 Wm E Jones

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1946, at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/27 19 46 to present 19 46

and that I last saw him alive on June 17 at 9:30 PM 19 46

Immediate cause of death Hypostatic pneumonia

Due to Coronary thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. L. Marlow, M.D.

Address 4601 Leland St. Date signed 6/18/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED  
JUN 27 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

06121

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Kensington  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
17 Everett St.  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Kensington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 17 Everett St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

## 3. (a) FULL NAME

Louis Boylan Noble

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Katherine Jane Noble  
 6.(c) If alive, give age 75 years  
 7. Birth date of deceased (mo., day, yr.) May 9, 1870  
 8. AGE: Years 76 Months — Days 24 If less than one day — hrs. — min.

9. Birthplace Goshen, Indiana  
 (Town, county, and state)  
 10. Usual occupation retired  
 11. Industry or business Insurance Salesman  
 12. Name Joseph M. Noble  
 13. Birthplace Ohio  
 14. Maiden name Abbie Boylan  
 15. Birthplace New York

16. Informant Mrs. Louis B. Noble  
 Address 17 Everett St., Kensington  
 17. Shipment Date thereof June 5, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Salem Church Cemetery  
 Location Dover, Pennsylvania  
 18. Funeral director Wm. Hansen Humphrey  
 Address Bethesda, Maryland  
 19. 6/5 48 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 46, at 9:40 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 19 46 to June 3 19 46  
 and that I last saw him alive on June 3 19 46  
 Immediate cause of death uremia  
 Due to cardio-vascular-renal disease  
 Due to —  
 Other conditions —  
 (Include pregnancy within 3 months of death)

## DURATION

2 weeks  
over 10 years

Major findings of operations — Date of op. —  
 Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide — Date of —  
 Where did injury occur? — (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) —  
 Means of injury — Injured at work? —

23. SIGNATURE Katherine A. Chapman, M.D.  
29 West Baltimore St. M. D. or other  
Kensington, Md. Address Date signed 6/3/46

RECEIVED

DATE

RECEIVED

JUN 10 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-24)

06122

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (if outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 28 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Texas County \_\_\_\_\_  
 City or town Brownville  
 (if outside city or town limits, write RURAL and give nearest town)  
 Street No. 1505 E. Jackson St.  
 (if rural, give LOCATION)  
 2.(a) if veteran, name war World War II ✓

## 3. (a) FULL NAME

NUNLEY, Sterling Griffin, Slc V-6 USNR

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) January 15, 1923 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 23 Months 5 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Texas  
 (Town, county, and state)

10. Usual occupation Navy

11. Industry or business \_\_\_\_\_

12. Name Sterling Griffin Nunley13. Birthplace Texas14. Maiden name Christina Perez15. Birthplace Texas16. Informant wife: Mrs. S. G. NunleyAddress 1505 E. Jackson St., Brownsville, Tex.

17. removal Date thereof 6-24-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Brownsville, Texas18. Funeral director Geo. W. Wise, J.C.F.Address 2900 M St., N.W., Wash. D.C.

19. 6-24- 46 Mary Charlotte Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 June 19 46 at 12:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 May 19 46 to 24 June 19 46  
 and that I last saw him alive on 24 June 19 46

Immediate cause of death Lymphosarcoma, generalized DURATION \_\_\_\_\_

Due to Primary, in left deep cervical chain of lymph nodes. Cervical.

Due to Duration: Approximately eight months.

Other conditions Widespread dissemination.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury Gun Blows Injured at work? \_\_\_\_\_

23. SIGNATURE J. M. BLOKOM, Jr., Lt.(jg) (MC) USNR  
 M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 6-24-46

82100

RECEIVED  
JUL 6 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1372)

## CERTIFICATE OF DEATH

06123

216

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital Bethesda, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rockville, Rt. #1  
(If rural, give LOCATION)2.(a) If veteran, name war ★

## 3. (a) FULL NAME

William (n) ODEN GMLC USN Ret. Inact.

## 3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>W-US</u>	6.(a) Single, married, widowed, or divorced
-----------------------	---------------------------------	---

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 26 Dec 1892

6.(c) If alive, give age ..... years

8. AGE:	Years <u>53</u>	Months <u>5</u>	Days <u>6</u>	If less than one day .....hrs. ....min.
---------	--------------------	--------------------	------------------	--

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation U.S. Navy (retired)

## 11. Industry or business

12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Sister: Mrs. Dorothy ConnollyAddress Rockville, Md. Rt. #117. Burial Date thereof 6-6-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director William Pumphrey Co. W.P.P.Address 7557 Wisc. Ave. Bethesda, Md.19. 2 June 1946 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1946 at 0204 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1946, to June 2 1946 and that I last saw him alive on June 1 1946Immediate cause of death Arteriosclerosis, general

## DURATION

Due to

Due to

Other conditions Thrombosis right coronary artery

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Arteriosclerosis kidneys

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. THOMPSON, Lt. Cdr. (MC) USNRAddress USNH Bethesda, Md. Date signed 6-2-46

RECEIVED

JUN 10 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 956

06124

## CERTIFICATE OF DEATH

Reg. Diat. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? half hour

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? half hour

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N.Y. CountyCity or town Buffalo  
(If outside city or town limits, write RURAL and give nearest town)Street No. 207 Breckenridge St.  
(If rural, give LOCATION) ★

2.(a) If veteran, name war

## 3. (a) FULL NAME

PARKHURST, Layton

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Mrs. Mayme Parkhurst

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 14, 18758. AGE: Years 70 Months 7 Days 18 If less than one day  
.....hrs. ....min.9. Birthplace Ind.  
(Town, county, and state)10. Usual occupation veteran

11. Industry or business

12. Name William Parkhurst13. Birthplace Ind. (dec)14. Maiden name Lucy Parr,15. Birthplace Ind. (dec)16. Informant wife: Mrs. Mayme ParkhurstAddress 207 Breckenridge St., Buffalo, 13, N.Y.17. burial Date thereof 6- 6 -46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. W. CHAMBERSAddress Georgetown, D. C.19. June 3 19 46 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2 June 19 46 at 11:05 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2 June 19 46, to 2 June 19 46and that I last saw him alive on 2 June 19 46

Immediate cause of death

Congestive heart failure

DURATION

Due to Aortic and mitralvalve diseaseDue to Rheumatic endocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Rheumatic valvular heart disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

E. F. Balsbaugh23. SIGNATURE E. F. BALSBAUGH, Lt. Comdr. (MC) USNRAddress USNH Bethesda, Md. M. D. or other 8-3-46

Date signed

RECEIVED

JUN 10 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06125

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Rosa Payne

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 15, 1898

8. AGE: Years 48 Months 1 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation Maid

11. Industry or business \_\_\_\_\_

12. Name -13. Birthplace -14. Maiden name Mary Cananough15. Birthplace Virginia16. Informant Hospital records

Address \_\_\_\_\_

17. Buried Date thereof June 28, 1946  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Lincoln ParkLocation Rockville, Md.19. Funeral director Robert L. SnowdenAddress 246 N. Wash. St.6-27 Rockville, Md.

19. (Date rec'd by registrar) \_\_\_\_\_

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 25, 1946 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19, 1946 to June 25, 1946 and that I last saw her alive on June 25, 1946

Immediate cause of death Post operative obstruction DURATION 3 weeks  
General peritonitis

Due to Bilateral SalpingitisDue to Bilateral cystic ovariesFibromyoma of the uterus

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Complete hysterectomy  
operation Date of op. 5-24-46

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Mrs. I M. D. or other \_\_\_\_\_

Address Sandy Spring, Md. Date signed 6/25/46

RECEIVED  
JUL 17 1946  
BUREAU 7 H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 576

06126

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Kensington View, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 Months

Hospital, institution, or street address where death occurred:

102 Upton Dr.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Kensington View, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 102 Upton Dr.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

MR. CHARLES DUARD PHILLIPS

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife

Amanda C.

7. Birth date of

deceased (mo., day, yr.)

March 22, 1876

B.(c) If alive, give age years

8. AGE:

Years

70

Months

2

Days

26

If less than one day

hrs.

min.

9. Birthplace

Charlottesville, Va.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER  
MOTHER

12. Name

Joseph Phillips

13. Birthplace

Virginia

14. Maiden name

Eliza Gillespie

15. Birthplace

Virginia

18. Informant

Mrs. Amanda C. Phillips

Address

102 Upton Dr. Kensington, Md.

17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof 6/21/46  
(month) (day) (year)

Cemetery or crematory

Ft. Lincoln Cemetery

Location

Maryland

18. Funeral director

Address

7557 Wis. Ave. Bethesda, Md.

19.

6/19 46  
(Date read by registrar)Wm E Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 19 46 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 3-1938 19 46 to June 18 19 46and that I last saw him alive on June 8, 1946 19 46

Immediate cause of death

Carcinoma of Prostate  
with extensive metastasis  
and cachexia.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Samuel B. Daughlin M.D.  
M. D. or other  
8252 E. Ave  
Date signed 6-19-46

CERTIFICATE OF DEATH

RECEIVED  
JUN 27 1946  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 62

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

### 1. PLACE OF DEATH:

County Montgomery  
City or town Brookville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 yrs  
Hospital, institution, or street address where death occurred:  
no  
How long in hospital or institution? no

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Montgomery  
City or town Brookville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mrs Mamie E. Powell

### 3. (b) Social Security Number

no

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced mar

8.(b) Name of husband or wife Austin Powell

7. Birth date of deceased (mo., day, yr.) Mar. 28-1875 6.(c) If alive, give age 75 years

8. AGE: Years 71 Months 2 Days 28 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chapel Hill, Tenn.  
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business farming

12. Name Jas M. Powell

13. Birthplace unknown

14. Maiden name Mary Blackwell

15. Birthplace Chapel Hill, Tenn

16. Informant Mrs Mary P. Higgins

Address 1221 S Thomas St. Washington 24

17. BURIAL Date thereof 6-28-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BROOKVILLE

Location BROOKVILLE MONTG CO MD

18. Funeral director Wm E. Ruppberg

Address Silver Spring, Md.

19. 6-27 19 46 Gertrude B. Lawler  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 46 at 2:58 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 19 46 to June 26 19 46 and that I last saw her alive on June 26 19 46

Immediate cause of death hyper-tension  
heart disease DURATION 3 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Chas C. Tumbleson

Address Sandy Springfield M. D. Chas C. Tumbleson

Date signed 6/26/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 17 1946  
BUREAU V K

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(722)

06128

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County..... Montg. Co.  
 City or town..... Washington Grove. Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 38 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montg.

City or town..... Washington Grove  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Albert Franklin Rabbitt

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

Male White Married

6.(b) Name of husband or wife..... Alice B Rabbitt

7. Birth date of deceased (mo., day, yr.)..... 6.(c) It alive, give age..... 88 years

8. AGE: Years Months Days If less than one day  
1951 95 3 28 hrs. min.9. Birthplace..... Maryland  
(Town, county, and state)

10. Usual occupation..... Retired Farmer

11. Industry or business..... II

12. Name..... William J Rabbitt

13. Birthplace..... Md

14. Maiden name..... Eliza Kemp

15. Birthplace..... Md

16. Informant..... Mary Rabbitt

Address..... Washington Grove. Md.

17. Burial Date thereof..... 6/15/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Forest Oak Cemetery

Location..... Gaithersburg Md.

18. Funeral director..... Ernest C Gartner

Address..... Gaithersburg. Md.

19. June 14 1946 Alvin L. Cooke  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 13 1946 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to June 13 1946

and that I last saw him alive on June 6 1946

Immediate cause of death.....

Acute Cardiac dilatation

Due to..... Chronic valvular heart

Due to..... disease

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... injured at work?

23. SIGNATURE..... F. Broschait M.D.  
Gaithersburg Md. M.D. or other

Address..... Date signed 6-13-46

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 15 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06129

## CERTIFICATE OF DEATH

Reg. Dist. No. 21516

## 1. PLACE OF DEATH:

County MONTGOMERY  
 City or town Bethesda, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 days  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital, Bethesda Md.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_  
 City or town Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 911 E. Capitol St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MINNIE C. ROGIER

## 3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED

6. (b) Name of husband or wife CHARLES F. ROGIER

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan 6 - 18778. AGE: Years Months Days If less than one day  
69 5 8 hrs. min.9. Birthplace Washington, D.C.  
(Town, county, and state)10. Usual occupation House wife11. Industry or business NONE12. Name Jacob Appich13. Birthplace GERMANY14. Maiden name CAROLINE ERNOID15. Birthplace GERMANY16. Informant Ruth R. CarterAddress 1019 Ohio Place NW.17. Burial, cremation, or removal. Which? Burial Date thereof 6/17/46  
(month) (day) (year)Cemetery or crematory Park CreekLocation Wash. DC.18. Funeral director The S. H. Hines CoAddress 2901-14 N.W. Wash. DC.19. 6/15 19 46 Mr E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 - 1946 at 6:05 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 - 1946 to June 13 - 1946 and that I last saw him alive on June 13 - 46Immediate cause of death Acute Cordic dilatation DURATION 2 hrDue to Circumferential leftfront. infarctingDue to this left lung.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Sinclair Bowser M.D. M. D. or otherAddress 3140 Kings Rd Date signed June 10, 46

RECEIVED

JUN 15 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1242

## CERTIFICATE OF DEATH

 ★ 06130  
 Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since May 16, 1946  
 Hospital, institution, or street address where death occurred:  
Suburban Hospt. 8600 Old Georgetown Rd.  
 How long in hospital or institution? Since May 16, 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_  
 City or town Washington, D. C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3941 Legation St. N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mr. Audley A. P. Savage

## 3. (b) Social Security Number

578-05-2459

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Winifred Austin  
 6. (c) If alive, give age 60 years  
 7. Birth date of deceased (mo., day, yr.) Jan. 12, 1883  
 8. AGE: Years 63 Months 5 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Kingston, Jamaic Brit. W. I.  
 (Town, county, and state)  
 10. Usual occupation Auditor, Natl. Savings & Trust Co.  
 11. Industry or business \_\_\_\_\_  
 FATHER 12. Name Edward Ashton Savage  
 13. Birthplace England  
 MOTHER 14. Maiden name Mary L. Surridge  
 15. Birthplace Jamaic

16. Informant Mrs. Winifred A. Savage  
 Address 3941 Legation St. N. W.

17. Burial Date thereof 6/15/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rock Creek Cemetery  
 Location Washington, D. C.

18. Funeral director Wm Reuben Humphrey  
 Address 7557 Wis. Ave. Bethesda, Maryland

19. 6/13 46 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 19 46 at 2:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15, 1945 to present 19 \_\_\_\_\_  
 and that I last saw him alive on 6/12/46 19 \_\_\_\_\_

Immediate cause of death Aspiration pneumonia  
 DURATION \_\_\_\_\_

Due to Hemorrhage into stomach from rupture of esophageal varices  
 DURATION \_\_\_\_\_

Due to Portal cirrhosis  
 DURATION \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results same  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. L. Markley M.D.  
 Address 4601 Leland St. Date signed 6/13/46  
 M. D. or other \_\_\_\_\_

RECEIVED

JUN 15 1946

BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH


06131

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 13 hours  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 13 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3104 P St., N.W.  
(If rural, give LOCATION)  
2(a) If veteran, name war Veteran  ☒

### 3. (a) FULL NAME

SHEA, William (n)

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male

W-US

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 20, 1885 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day  
60 8 0 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace N.Y.  
(Town, county, and state)

10. Usual occupation veteran

11. Industry or business

FATHER 12. Name Richard Shea

13. Birthplace N.Y. dec.

MOTHER 14. Maiden name Mary Drennan

15. Birthplace N.Y. dec.

16. Informant brother: Mr. Joseph Shea

Address 3104 P St., N.W., Wash., D.C.

17. burial Date thereof 6-22-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director S. H. Hines

Address 2901 14th St., N.W., Wash., D.C.

19. 6-20 46 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 20 June 19 46, at 7:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 June 19 46, to 20 June 19 46

and that I last saw him alive on 20 June 19 46

Immediate cause of death far advanced subcutaneous meningitis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. H. C. Smith, Comdr. (MC) USNR

Address USNH Bethesda, Md. Date signed 6-20-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6/26/46

RECEIVED

JUL 3 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH



06132

Reg. Dist. No. 213

### 1. PLACE OF DEATH:

County Montgomery

City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Avery Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Clarise HARRIS Smith

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Grant Smith

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1873

8. AGE: Years 73 Months 5 Days 20 If less than one day  
.....hrs. ....min.

9. Birthplace Rockville, Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Daniel Harris

13. Birthplace Weaverton, Maryland

14. Maiden name MARtha Harris

15. Birthplace Weaverton

16. Informant MARIE HILL, daughter

Address 722 Kenyon St., N.W., D.C.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 29, 1946  
(month) (day) (year)

Cemetery or crematory Lincoln Park Cemetery

Location Rockville, Md.

18. Funeral director R. L. Snowden

Address Rockville, Md.

19. 6/29/46 Josephine D. Watson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 46 at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to June 26 19 46

and that I last saw him alive on June 25 19 46

Immediate cause of death.....

Pulmonary Embolism DURATION 20

Due to.....

Femoral Thrombophlebitis 3W

Due to.....

Other conditions Coronary Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William W. H. R. L.

Address Rockville M. D. or other

Date signed 6/26/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 2 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1242)

## CERTIFICATE OF DEATH

06133

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 Days  
 Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 15 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... W. Va. County...  
 City or town... Martinsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 119 E. Martin St. N.  
 (If rural, give LOCATION) ★  
 2. (a) If veteran, name war... World War One ✓

## 3. (a) FULL NAME

Edward Ottibine SMITH

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife... Mrs. Edward O. Smith  
 7. Birth date of deceased (mo., day, yr.) Dec. 28, 1888 6. (c) If alive, give age... years  
 8. AGE: Years 57 Months 5 Days 28 It less than one day  
hrs. min.

9. Birthplace... West Virginia  
 (Town, county, and state)  
 10. Usual occupation... veteran  
 11. Industry or business  
 12. Name... John Smith (dec.)  
 13. Birthplace... W. Va.  
 14. Maiden name... Mary Miller (dec.)  
 15. Birthplace

16. Informant... Mrs. E.O. Smith  
 Address... 119 E. Martin St., Martinsburg, W. Va.  
 17. burial Date thereof... (month) (day) (year)  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory... Rosedale  
 Location... Martinsburg, W. Va.  
 18. Funeral director... W. W. CHAMBERS CO.  
 Address... 1400 Chapin St. N.W. Wash., D.C.  
 19. 27 June 19 46  
 (Date rec'd by registrar) Mary Charlotte Smith Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 26 June 19 46 at 6:23 p.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 12 19 46 to June 26 19 46  
 and that I last saw him alive on 26 June 19 46

Immediate cause of death  
Cirrhosis, liver atrophic  
Pulmonary Edema, terminal

## DURATION

Due to...  
 Due to...  
 Other conditions... Pneumoditis, adhesive  
Pan Sinusitis  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...  
 Autopsy results... confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE... C. B. SHULER, Comdr. (MC) USN  
J. B. Shuler  
 USNH Bethesda, Md. M. D. or other 6-27-46  
 Address... Date signed

RECEIVED  
JUL 6 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06134

Reg. Dist. No. 2.16

### 1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 3 days

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? since March 29/46

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_

City or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5209 14th St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Miss Jessie Smith

### 3.(b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced single

8.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 30, 1893

8. AGE: Years 53 Months 0 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Kentucky  
(Town, county, and state)

10. Usual occupation clerk

11. Industry or business Navy Dept.

12. Name Smith

13. Birthplace Kentucky

14. Maiden name Luckridge

15. Birthplace Kentucky

16. Informant Hospital Records

Address \_\_\_\_\_

17. Wash. D.C. Date thereof June 1, 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Marshall Park

Location Mr. Sterling Ky.

18. Funeral director Wash. Funeral Home

Address 1756 Pa Ave. N.W.

19. 6/1 46 John E. Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1946 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2, 1946 to June 1, 1946

and that I last saw him alive on May 31, 1946

Immediate cause of death Cardiac Failure

DURATION

Due to Rheumatic Heart Disease

Due to Rheumatic Fever (as child)

Other conditions Pulmonary Embolism

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William Robert Perkins M.D.

Address 1463 Rhode Island Ave. Wash. D.C.

Date signed June 1, 1946

RECEIVED  
JUN 12 1946  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 hrs.Hospital, institution, or street address where death occurred: Suburban HospitalHow long in hospital or institution? 2 1/2 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 193 Burdette Rd. Apt 3.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Paul Baby (Lowell) Smith

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

maleW.

6. (b) Name of husband or wife

another Mrs. Inez Smith

7. Birth date of

deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

2 1/2 hours old (newborn) min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address 193 Burdette Rd - Bethesda Md #1

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 46

Wm E. Jones  
Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 12 1946 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/11/46 1946 to present 1946and that I last saw him alive on 6/12/46 1946

Immediate cause of death

Prematurity + atelectasis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. L. Marks, M.D.

M. D. or other

Address

4601 Leland St.Date signed 6/12/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

JUN 15 1946

RECEIVED

JUN 15 1946

RECEIVED

RECEIVED

JUN 15 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B12)

## CERTIFICATE OF DEATH

06136

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General HospitalHow long in hospital or institution? 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Sandy Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Walter S. Spriggs

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Dec. 10, 1867

8. AGE:

Years

Months

Days

If less than one day

78529

hrs.

min.

9. Birthplace Mt. Zion, Maryland  
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

MOTHER FATHER

12. Name William Henry Spriggs13. Birthplace haytownville, Maryland14. Maiden name Hattie Mitchell15. Birthplace haytownville, Maryland16. Informant Hospital records

Address

17. Burial Date thereof June 13, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sandy Spring CemeteryLocation Sandy Spring, Md18. Funeral director R. L. Snowden

Address

Rockville, Maryland19. June 13 1946 Gertrude B. Lawler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1946 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 25, 1946 to June 9, 1946and that I last saw him alive on June 9, 1946

Immediate cause of death

hypertensive heart disease with atherosclerosis, nephritis

DURATION

3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

C. C. Tumbleson

M. D. or other

Address Sandy Spring, Md Date signed 6/10/46

RECEIVED

JUN 25 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age & date of birth of deceased **MARYLAND STATE DEPARTMENT OF HEALTH**  
is shown on 2411 N. Charles St., Baltimore 77

06137

FILM No. I 06 JUL 17 1946 **CERTIFICATE OF DEATH**

Reg. Dist. No. 514

**1. PLACE OF DEATH:**

County Montgomery

City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Hancock Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**

Thomas Steward

**3. (b) Social Security Number**

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

7. Birth date of  
deceased (mo., day, yr.)

7/14/61 December 26, 1865

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

81 84

hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Thomas Steward

13. Birthplace Maryland

14. Maiden name Elizabeth Edmonston

15. Birthplace Maryland

16. Informant Emma M. Jones

Address Takoma, Park, Md.

17. Burial  
(Burial, cremation, or removal. Which?)

Burial Date thereof July 2, 46  
(month) (day) (year)

Cemetery or crematory Good Hope Church Cem.

Location Colesville, Md.

18. Funeral director R. B. Snowden

Address Rockville, Md.

19. July 1 19 46

(Date rec'd by registrar)

Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 29 19 46 at 11:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24 19 46 to June 29 19 46

and that I last saw him alive on June 28 19 46

Immediate cause of death

enteric sclerosis

DURATION

14 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

6911 S. 8th St. NW

M. D. or other

Date signed 6/29/46

RECEIVED  
JUL 10 1945  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on Film No. 106 - 7/24/46 is especially important. Physicians: please write the causes of death clearly and legibly.

## Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

of deceased is shown on

Film No. 106 - 7/24/46

2411 N. Charles St., Baltimore 33-2

## CERTIFICATE OF DEATH

06138

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

14 Cleveland Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County MontgomeryCity or town Takoma Park Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 Cleveland Ave Takoma Park Md  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

George William Stuart

## 3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Lillie Stuart8. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) July 15 - 18618. AGE: Years 6+ Months 84 Days hrs. min.9. Birthplace Wash. DC  
(Town, county, and state)10. Usual occupation clerk

11. Industry or business

12. Name Wm Stuart13. Birthplace DC14. Maiden name Fannie15. Birthplace DC18. Informant Lillie StuartAddress 14 Cleveland Ave Takoma Park Md17. Burial Date thereof 6/27/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory 1400 Chapin St. NWLocation Wash DC18. Funeral director Wm Chambers &Address 1400 Chapin St NW19. June 27 18. 46

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 19 46 at 5:00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 46 to June 27 19 46and that I last saw him alive on June 26 19 46Immediate cause of death arterio-sclerosisDURATION brief

Due to

Due to

Other conditions Cerebral hemorrhage 24 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm Chambers &Address 6811 5th St NW Date signed 6/27/46

Wash. DC.

RECEIVED

JUL 1 1945

BUREAU VS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06139

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 days  
Hospital, institution, or street address where death occurred:  
USNH Bethesda, Md.  
How long in hospital or institution? 15 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 220 W St., N.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

SULLIVAN, Edward Patrick

### 3. (b) Social Security Number

4. Sex MALE 5. Color or race W-US 6.(a) Single, married, widowed, or divorced \_\_\_\_\_

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) January 10, 1896 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 50 Months 5 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wash., D.C.  
(Town, county, and state)

10. Usual occupation veteran

11. Industry or business \_\_\_\_\_

FATHER 12. Name Dennis A. Sullivan

13. Birthplace Wash., D.C. dec.

MOTHER 14. Maiden name Addie McGuire

15. Birthplace Wash., D.C. dec.

16. Informant bro: Mr. John Sullivan  
Address 220 W St., N.E., Wash., D.C.

17. BURIAL Date thereof 6-15-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director Robert A. Mattingly

Address 131 11th St., S.E., Wash., D.C.

19. 13 June 19 46 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 13 June 19 46, at 12:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 May 19 46 to 13 June 19 46

and that I last saw him alive on 13 June 19 46

Immediate cause of death 1  
Tuberculous meningitis DURATION 5 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Tuberculosis, pulmonary, ft. ?

Tuberculosis pneumonia, bilateral 6 days  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R R Morris  
R. R. MORRIS, Lt.(MC) USNR

Address USNH Bethesda, Md. M. D. or other 6-13-46  
Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6/26/46

RECEIVED  
JUL 3 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

06140

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 hours  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 8 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County .....  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 529 9th St., N. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

TAYLOR, Baby Boy

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced infant  
 6.(b) Name of husband or wife .....  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) 2 June 1946  
 8. AGE: Years Months Days If less than one day  
9 hrs. 36 min.

9. Birthplace Bethesda, Md.  
 (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

12. Name Glenn Erwin Taylor13. Birthplace New Orleans, La.14. Maiden name Nancy Savage15. Birthplace Boston, Mass.16. Informant father: Mr. Glenn TaylorAddress 529 9th St., N.E., Wash., D.C.

17. burial Date thereof 6-3-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory George Washington MemorialLocation Maryland Hyattsville18. Funeral director W. W. ChambersAddress 1400 Chapin St., N. W., Wash., D.C.19. 6-3 46 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 2 June 19 46 at 9:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2 June 19 46 to 2 June 19 46  
 and that I last saw him in alive on 2 June 19 46

Immediate cause of death Atelectasis  
lung

Due to Premature Birth

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Autopsy results only atelectasis lungs Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul PETERSON Captain (MC) USN

M. D. or other 6-3-46

Address USNH Bethesda, Md. Date signed .....

RECEIVED

JUN 10 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

 06141  
 Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 days  
 Hospital, institution, or street address where death occurred:  
Wash. San + Hospital  
 How long in hospital or institution? 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Col. County \_\_\_\_\_  
 City or town Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3522 Quesada St. N.W.  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Thompson - Mrs. Mary Alice

## 3.(b) Social Security Number

4. Sex fe 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Mr. George Thomas Thompson  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept. 14 - 1873  
 8. AGE: Years 72 Months 8 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hertfordshire, England  
 (Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

16. Informant Records Wash. San + Hosp.  
 Address Takoma Park Md.

17. (Burial, cremation, or removal, which?) Funeral Date thereof June 13 1946  
 (month) (day) (year)

Cemetery or crematory Greenwood

Location Washington D.C.

18. Funeral director Lee Funeral Home

Address 300 - 4th St. N.E.

19. June 11 1946 (Date rec'd by registrar) Registrar Wm. D. Doherty

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1946 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14, 1942 to June 11, 1946

and that I last saw him alive on June 11, 1946

Immediate cause of death Coronary Vascular Disease

Due to Cardiac Infarct

Due to Chr. congestive cardiac failure

Other conditions Prob. terminal pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul V. Starrs, M.D.

Address Takoma Park, Md. Date signed 6-11-46

RECEIVED  
JUN 15 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06142

Reg. Dist. No. 213.

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rockville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Months

Hospital, institution, or street address where death occurred:

Rockville, Maryland R.F.D. # 3How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville, Md. R.F.D. # 3  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rockville, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Norman L. Thompson

## 3. (b) Social Security Number

212-20-1300

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Florence

## 7. Birth date of deceased (mo., day, yr.)

Mar. 5, 19236. (c) If alive, give age 22 years

## 8. AGE:

23

Years

Months

Days

If less than one day

421

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

William Thompson

## 13. Birthplace

Maryland

## 14. Maiden name

Virgie Belt

## 15. Birthplace

Maryland

## 16. Informant

Mrs. Florence Thompson

## Address

Rockville, Md. R.F.D. # 3

## 17.

Burial

Date thereof

6/29/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetary or crematory

Forest Oak Cemetery

## Location

Gaithersburg, Md.

## 18. Funeral director

Wm Reuben Simpney

## Address

Rockville, Maryland

## 19.

(Date rec'd by registrar)

Josephine D. Hutton

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med. Exam 1946 and that I last saw him alive on June 19 1946

Immediate cause of death

Coronary embolism

## DURATION

did  
suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Branstetter M.D.

M. D. or other

Address Gaithersburg, Md. Date signed 6-26-46

RECEIVED  
JUL 1 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

★ 06143  
Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7906 Georgia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

WILLIAM H. THOMPSON

## 3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

separated6. (b) Name of husband or wife Evelyn Thompson

6. (c) If alive, give age.....years

7. Birth date of

deceased (mo., day, yr.) April 9, 1884

8. AGE:

Years

Months

Days

If less than one day

6223

hrs.

min.

9. Birthplace Ednor, Maryland

(Town, county, and state)

10. Usual occupation Owner and operator of a taxicab

11. Industry or business

FATHER

12. Name Benjamin F. Thompson13. Birthplace Montgomery County, Md.

MOTHER

14. Maiden name Amanda C. Flook15. Birthplace Frederick County, Md.16. Informant George Ray ThompsonAddress 9312 Glenville Rd., Silver Spring17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 15, 1946  
(month) (day) (year)Cemetery or crematorium Burtonsville Union CemeteryLocation Burtonsville, Maryland18. Funeral director Waxner E. PumphreyAddress Silver Spring, Md.19. June 14 19 46  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 46, at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 3 19 46, to June 12 19 46  
and that I last saw him alive on June 12 19 46

Immediate cause of death

Cardiac failure

DURATION

terminal

Due to

Generalized arteriosclerosis5 yrs.

Due to

Thrombosis of popliteal artery of leg with embolism6 wks.

Other conditions

Splenomegaly6 wks.

(Include pregnancy within 3 months of death)

Major findings of operations

Bifurcation of thrombosis of popliteal arteryDate of op. June 10, 1946Autopsy results Report in files and by Dr. Frank A. Zack  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed June 13/1946

RECEIVED  
JUN 19 1946  
BUREAU V 8

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 24 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 24 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County .....  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 206 9th St., N.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

TURNER, Aaron Joshua

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Mrs. Emma L. Turner  
6.(c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) June 12, 1882  
8. AGE: Years 64 Months 0 Days 4 If less than one day ..... hrs. .... min.

9. Birthplace Md.  
(Town, county, and state)

10. Usual occupation retired

11. Industry or business

12. Name Richard O. Turner  
13. Birthplace Md. dec.

14. Maiden name Barbara Brookbank  
15. Birthplace Md. Md. dec.

16. Informant Wife: Mrs. Emma L. Turner  
Address 206 9th St. N.E., Wash., D.C.

17. burial Date thereof 6-12-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Va.

18. Funeral director Deal Funeral Home  
Address 816 H St., N.E., Wash., D.C.

19. 6-17 19 46 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH 16 June 19 46 at 8:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 May 19 46 to 16 June 19 46  
and that I last saw him alive on 16 June 19 46

Immediate cause of death Cerebral infarction  
DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. M. Bloxom, Jr. (MC) USN  
J. H. Bloxom, Jr. (MC) USN  
M. D. or other

Address USNH Bethesda, Md. Date signed 6-17-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6/26/46

RECEIVED  
JUN 27 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

06145

Reg. Dist. No. 213-

## 1. PLACE OF DEATH:

County Montgomery CountyCity or town Rockville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yearsHospital, institution, or street address where death occurred:  
306 Reading Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 306 Reading Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

ANDREW WALTER TURSKI

## 3. (b) Social Security Number

578-05-3397

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife Hazel A.8.(c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) Jan. 6, 18928. AGE: Years 54 Months 5 Days 1 If less than one day  
.....hrs. ....min.9. Birthplace Poland

(Town, county, and state)

10. Usual occupation Butcher- American Stores

11. Industry or business

12. Name Unknown13. Birthplace Poland14. Maiden name Unknown15. Birthplace Poland16. Informant Mrs. Hazel A. TurskiAddress 306 Reading Ave. Rockville, Md.17. Burial Date thereof June 10, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill CemeteryLocation Maryland18. Funeral director Dom. Funeral HomeAddress 7557 Wis. Ave. Bethesda, Md.19. 6/10/46 Josephine D. Houston

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1946 at 7:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 to June 7 and that I last saw him alive on June 6 1946.Immediate cause of death Coronary occlusionDURATION few minutesDue to Cardiovascular diseaseDue to with cardiac hypertrophy & decompensation 2 monthsOther conditions Obesity 5 years

(Include pregnancy within 8 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. J. Luthman, M.D. M. D./or otherAddress Rockville, Md. Date signed 6/10/46

RECEIVED

JUN 14 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

## CERTIFICATE OF DEATH

06146

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 189 days

Hospital, institution, or street address where death occurred:

Washington Sanatorium & Hospital

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington, D.C.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 Upshur St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

EDWARD L. WEBER

### 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Mary B. Weber

7. Birth date of

deceased (mo., day, yr.)

July 28, 1891

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

54

10

24

hrs.

min.

9. Birthplace

Philadelphia, Penna.  
(Town, county, and state)

10. Usual occupation

clerk

11. Industry or business

Navy Yard

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Sanatorium Record

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

June 24, 1946  
(month) (day) (year)

Cemetery or crematory

Location

19. Funeral director

Address

19.

June 24, 46  
(Date rec'd by registrar)

19.

46

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mon. June 24, 1946 at 3:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 26, 1946 to June 24, 1946

and that I last saw him alive on

June 22, 1946

Immediate cause of death

Generalized Carcinoma-  
atosis.

DURATION

1 mo.

Due to Primary Carcinoma of  
Rectum and Recto sigmoid. 1 yr?

Due to

Other conditions Ileo-sigmoid Fistula 3 mos.

(Include pregnancy within 8 months of death)

Major findings of operations

Carcinoma Rectum and  
recto-sigmoid. Date of op. Mar. 6, '46

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Silver Spring, Md. Date signed 6-24-46

RECEIVED

JUN 27 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06147

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County MontgomeryCity or town Poolesville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County MozztgCity or town Poolesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Nellis White Williams

## 3.(b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Harry Williams

7. Birth date of

deceased (mo., day, yr.)

Oct 6 - 18678.(c) If alive, give age 71 years

8. AGE:

Years

Months

Days

If less than one day

7081

.....hrs.

.....min.

9. Birthplace

Dickerson, Montgla Md  
(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

FATHER

12. Name

Franklin White

13. Birthplace

Md

14. Maiden name

Margaret Allnutt

15. Birthplace

Md

18. Informant

Harry Williams

Address

Poolesville Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

6/10/46  
(month) (day) (year)

Cemetery or crematory

Monocacy

Location

Beallsville

18. Funeral director

William B Hiltz

Address

Barnesville, Md

19.

(Date rec'd by registrar)

19.

46Charles W. Egan

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 71946 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to 1946  
and that I last saw him alive on June 7

Immediate cause of death

Inter cranial hemorrhage

DURATION

20 days

Due to

fracture of skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-18-46Where did injury occur? Barnesville Mont Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) home of friendMeans of injury Fell down steps Injured at work? no

23. SIGNATURE

Frank J. Brochard

M. D. or other

Address

1111 N. Charles St.Date signed 6-8-46

RECEIVED

JUN 19 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

06148

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Poolesville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Virginia Mae  
Wims

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

Caucasian

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

June 25, 1946

## 8. AGE:

Years

Months

Days

If less than one day

0

0

0

0 hrs.

10 min.

## 9. Birthplace

Poolesville Montg Co. Md  
 (Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

Seymour Thomas

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Mildred J. Wims

## 15. Birthplace

Maryland

## 16. Informant

Polly Bell

## Address

Poolesville, Md.

## 17.

Burial  
 (Burial, cremation, or removal. Which?)

## Date thereof

June 26, 1946  
 (month) (day) (year)

## Cemetery or crematory

Family lot at home

## Location

Poolesville, Maryland

## 18. Funeral director

Martha Doney (grandmother)

## Address

Poolesville, Maryland

## 19.

June 26, 1946  
 (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Poolesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

## Street No.

(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 19 46 at 10:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/25 19 46 to 6/25 19 46

and that I last saw him alive on 6/25 19 46

Immediate cause of death

Pneumonia 6 mos.  
(Cause unknown)

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury

Injured at work?

23. SIGNATURE

Byron D. White, M.D.  
 M. D. or other

Poolesville, Md. Date signed 6/26/46

RECEIVED

JUL 15 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Department of Commerce  
Bureau of the Census

CERTIFICATE OF DEATH  
COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

State File No.

06149

Registered No.

216

## 1. PLACE OF DEATH

- (a) County Montgomery Registration district No. \_\_\_\_\_ (For reg. use)
- (b) Magisterial district \_\_\_\_\_
- (c) City or town Cherry Chase
- (d) Name of hospital or institution 7405 Bybrook Lane
- (e) Length of stay in hosp. or inst. 6 mo In this community 6 mo  
(Specify whether years, months, or days)
- (f) Is place of death within corporate limits? \_\_\_\_\_

## 2. USUAL RESIDENCE OF DECEASED

- (a) State N.Y.
- (b) County \_\_\_\_\_
- (c) City or town Rome Street No. \_\_\_\_\_
- (d) Is place of residence within corporate limits? \_\_\_\_\_
- (e) Citizen of foreign country? \_\_\_\_\_ (Yes / No) ☒
- If Yes, name country \_\_\_\_\_

## 3. (e) FULL NAME

EDNA S WOLFF

3. (b) If veteran,  
name war3. (c) Social security  
number

(Answer only if card is available)

4. Sex Female 5. Color or race White 8. (a) Single, married, widowed, divorced. Married

- (b) Name of husband or wife Edward A Wolf

7. Date of birth of deceased July 5 1902  
(Month by name) (Day) (Year)

8. Age: Years 43 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hours \_\_\_\_\_ min.

9. Birthplace Lee Center New York  
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

## 11. Industry or business

- Father { 12. Name Edmund L Shepard  
13. Birthplace Lock Falls New York  
(City, town, or county) (State or foreign country)

- Mother { 14. Maiden name Adeline Farrington  
15. Birthplace Constanti New York  
(City, town or county) (State or foreign country)

18. (a) Informant's own signature Ruth C. Shepard

- (b) Address 7405 Bybrook Ln - Ch Ch Rd

17. (a) Burial, cremation, or removal? Shipment To  
Rome, N.Y. Date 6/11/46  
(Month by name) (Day) (Year)

18. (e) funeral director W W Chambers Co

- (b) Address 3072 M St NW  
Washington D.C.

19. (a) Filed 6/19 1946 (Date received by reg.) (Local, deputy, or sub-registrar's own signature) Tom E Jones

## MEDICAL CERTIFICATION

20. Date of death JUNE 9 1946 at 2:26 M  
(Month by name) (Day) (Year) (Hour)

21. I hereby certify that I attended the deceased from JANUARY 1946  
to 9 JUNE 1946; that I last saw her alive on 9 JUNE 1946

and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA  
UTERUS, FUNDAL

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Name of operation BIOPSY

Date of operation SEPT. 1945 Major findings: (a) of operations

CARCINOMA

(SYRACUSE MEMORIAL  
HOSPITAL)

(b) of autopsy \_\_\_\_\_

Physician

Underline  
the primary  
cause to  
which death  
should be  
charged  
statistically.

## 22. If death was due to external causes fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_
- (b) Date of occurrence \_\_\_\_\_
- (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)
- (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_ While at work? \_\_\_\_\_
- (Specify type of place) \_\_\_\_\_
- (e) Means of injury \_\_\_\_\_

23. Signature W. H. Price M. D., Cor., or other June 1946  
Address Comdr, MC USNR Date signed June 1946  
4514 13TH ST NW Wash, D.C.

RECEIVED  
JUN 15 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-4)

## CERTIFICATE OF DEATH

06150

Reg. Dist. No. 2231

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 mo

Hospital, institution, or street address where death occurred:

29 Carroll AveHow long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Mass. County —City or town Milton  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 Clark Rd.  
(If rural, give LOCATION)2.(a) If veteran, name war II

## 3. (a) FULL NAME

Arthur C. Woodward

## 3. (b) Social Security Number

012-09-7815

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single.

6. (b) Name of husband or wife

—6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Jan. 25, 1918

8. AGE:

Years

Months

Days

If less than one day

2846— hrs.— min.

9. Birthplace

Mass.  
(Town, county, and state)

10. Usual occupation

DISCHARGED SOLDIER

11. Industry or business

Insurance Clerk

MOTHER

FATHER

12. Name

Dr. Woodward

13. Birthplace

Milton, Mass.

14. Maiden name

Dorothy Salik

15. Birthplace

Milton Mass.

16. Informant

J. E. McKenny

Address

29 Carroll Ave. Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?)

RemovalDate thereof June 1, 1946  
(month) (day) (year)

Cemetery or crematory

Takoma Park D. Quinney, Mass.

Location

J. Arthur Walters

18. Funeral director

Address 254 Carroll St. N. W.

19. Date rec'd by registrar

June 1, 1946

19. Date

467W. H. H. H.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1946, at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1945 to June 1, 1946and that I saw him alive on June 1, 1946

Immediate cause of death

Typhoid due to  
illuminating gas  
Due to inhalation

DURATION

Found  
dead in  
home

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 6-1-46

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brounch M. J.

M. D. or other

Address epithetbury mdDate signed 6-1-46

RECEIVED

JUN 5 1946

BUREAU V. G.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Suburban Bethesda (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 hours 40 minutes  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital, Gent. Rd.  
 How long in hospital or institution? 6 hours, 40 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bonds  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route 2  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Baby Boy Yokley

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) June 3, 1946  
 8. AGE: Years Months Days If less than one day  
6 hrs. 40 min.

9. Birthplace Rural Bethesda, Montgomery - Md.  
 (Town, county, and state)  
 10. Usual occupation.....  
 11. Industry or business.....

12. Name Gilbert F. Lowe  
 13. Birthplace Trivilla, Maryland  
 14. Maiden name Virginia Mae Yokley  
 15. Birthplace Kings Port, Tennessee

16. Informant Minnie Mae Yokley  
 Address Boyle, Maryland  
 17. Burial Date thereof Jun 4, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cemetery Cedar Grove  
 Location Montgomery County

18. Funeral director Ray Barber  
 Address Laytonsville, Md.  
6-4-46 19. (Date rec'd by registrar)  
W.D. Jones Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 3 19 46 at 7:40 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1:00 AM JUNE 3 19 46, to 7:40 AM JUNE 3 19 46and that I last saw him alive on JUNE 3 19 46

Immediate cause of death..... DURATION

PREMATURITY

Due to.....

Due to.....

Other conditions CHILD WAS BORN IN  
SIXTH MONTH OF GESTATION.  
 (Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE W.D. Jones M.D.  
 M. D. or other  
 Address Suburban Hosp.  
Bethesda Md. Date signed Jun 3, 1946

RECEIVED

JUN 10 1943

BUREAU VI